DOCUMENT RESUME

ED 414 553 CG 028 217

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TITLE	Health of Children of the Working Poor: Description and Intervention.
PUB DATE	1997-08-00
NOTE	19p.; Paper presented at the Annual Meeting of the American Psychological Association (105th, Chicago, IL, August 15-19, 1997).
PUB TYPE	Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Adolescents; *Child Health; Children; *Diseases; *Economically Disadvantaged; Elementary Secondary Education; Health Care Costs; *Health Needs; *Health Services; Hispanic Americans; Poverty
IDENTIFIERS	Latinos

ABSTRACT

More and more often, children in the United States are denied services that help keep them healthy or heal them when they are ill. This study examines the demographic, psychological, and physical health status of a group of children (N=293) with no access to health care, and who experienced an acute health problem. The children ranged in age from 3 to 18 years. Over three quarters were Latinos and 37% of the acute health problems involved dental needs. Two important issues are examined: a comparison of the opinions of the treated children's parents, referring school nurses, and medical providers concerning the potential disruption to the children's immediate school attendance and functioning; and a portrayal of the differential perceptions of the children's parents and school nurses concerning the psychological motivations of the parents to obtain care for their children's acute health problems. The results underscore the importance of early attention to acute childhood health problems: (1) parents who are unable to provide medical care for their children do notice that their children need care and are active in trying to access healthcare for their children; (2) medical professionals must be taught that most lower, middle class parents, often termed the "working poor," do try very hard to procure physical health care for their children; and (3) too many children and falling through the cracks of the U.S. health care system. The average estimated monetary cost for each acute care service provided was $350, with 70% of nurses, 70% of parents, and 38% of health care providers reporting that the health problem was moderately to highly interfering with the child's school functioning. (RJM)

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ED 414 553

Health of Children of the Working Poor: Description and Intervention

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Poster presented at the annual meetings of the American Psychological Association, Chicago, IL, August, 1997

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INTRODUCTION

Developmental psychologists are increasingly aware of the critical role of physical health in children's ability to develop into functional and productive individuals. More and more often, U.S. children are denied the services that help keep children healthy and heal them when they are ill. Across a wide variety of disciplines concerned with children's optimal development, it has been undeniably established that the frequency, patterns, and treatment histories of children's acute physical health problems, such as earaches or injuries, are major influences on concurrent and subsequent competence and quality of life.

Developmental psychologists are also recognizing their important role in development theory and its application regarding the psychosocial parental and child determinants of children's physical health. Parent health beliefs are inextricably linked to both parents' health behavior on behalf of their children, and family patterns of socializing children's health beliefs and behavior. Medical professionals' perceptions or stereotypes of parents' beliefs about children's health mediate both access to and quality of child health care. Finally, teachers have always known that children must be physically healthy to be able to learn, think, and otherwise benefit from and function in school. Tired, undernourished, or ill children cannot maximally prosper cognitively, socially, or emotionally, within the school setting, or anywhere else.

Don't most children, either as a benefit of private or public health insurance enjoy adequate access to timely care for acute health problems such as sore throats, earaches, toothaches, or injuries? Unfortunately not. Although many of us, as demonstrated by public opinion polls, believe that all working families with children have health insurance through their

employment, and all other families receive childhood medical service through Medicaid or similar public health programs, neither of these assumptions is true. Many of the working poor, particularly those with young children, are self-employed or work for companies that do not provide health insurance, and many of the nonworking poor are not eligible for Medicaid.

Thus, while the current U.S. health care system provides care for the children of middle class families through private insurance and managed care, and children in impoverished families are provided health care through federal and state welfare programs, a significant minority of families with young children (e.g., the working poor) have no access to either of these sources of health care, due to a combined inability to afford insurance or qualify for state and federal health benefits.

This study examined the demographic, psychological, and physical health status of a group of children with no access to health care, when referred to treatment for an acute health problem by a volunteer health care delivery program for children. Two important issues are examined:

1) After documenting the demographic characteristics of the parents of the children treated in this program, a comparison is made of the estimates of the treated children's parents, referring school nurses, and medical providers concerning the potential disruption to the children's immediate school attendance and functioning, and ultimate societal lifetime productivity should the children's health problems been left untreated.

2) In order to portray the differential perceptions of the children's parents and school nurses concerning the psychological motivations of these children's parents to obtain care for their children's acute health problems, associations among assessments of parental health personal control

constructs, and parents' perception of control over their children's health were measured.

METHOD

Sample

School children (N=293) referred by Project K.I.N.D. (Kids in Need of Doctors) to receive acute health care were participants in this study. Project K.I.N.D., located in a large southern California county, uses the volunteer services of a county medical community to provide free health care for those children who have no access to Medical/Medicaid, no health insurance, and whose parents are unable to afford the cost of care for an acute health problem. These children are referred from county schools by school district personnel such as teachers, secretaries, nurses and principals. Children are eligible to be referred if their parents state that they have no other resources available to obtain the needed care for their children.

Procedure and Measures

- Demographic Information (provided by mothers)
  - ethnicity
  - occupation status of parents
  - household structure, etc.
- Description of Children's Acute Health Problem (provided by mothers)
- Ratings of Mothers' Beliefs Concerning Influence on Children's Health (provided by mothers and school nurses)
- Characteristics of Acute Health Services Provided (provided by physicians and their staffs)
  - complexity
  - time spent
  - cost of service
  - diagnosis, etc.

- Estimates of Consequences of Nontreatment (provided by school nurses and physicians and their staff)
- Estimates of Acute Health Problem Interfering with School (provided by school nurses and physicians and their staff)
- Estimates of Length of Time Child had Suffered from Health Problem Being Treated (provided by school nurses and physicians and their staff)

GENERAL CHARACTERISTICS OF THE REFERRED FAMILIES

- Participants

  293 children referred by Project K.I.N.D. (Kids in Need of Doctors) to receive health care within 22 months across 1995-1997

- Gender

  57% males

  43% females

- Age

  Ranged from 3-18 years (mean = 8.8)

- Ethnicity

  77% Latino

  16% Euro-American

  7% African-American, Asian-American, or unspecified immigrants

- Family Structure

  - 21% of the families referred were single-mother-headed families
  - Average parent-to-child ratio in the households was 2 adults to 5 children

- Parent Employment
    - 21% of the fathers and 75% of the mothers of the children were unemployed
    - For those who were employed, 90% of the fathers and 86% of the mothers held occupations which ranged from menial service work, to unskilled work, to semiskilled work
- Types of acute health problems treated
    - 37% dental
    - 15% eye
    - 13% skin
    - 12% injuries or accidents
    - 8% illnesses
    - 7% ear
    - 3% mental
    - 5% other problems
- History of acute health problem
    - Providers reported 40% of the children had suffered with their health problem for between 1-10 days, while 60% of the children had endured their health problem for between two weeks to over one year

- Previous attempts to access health care
    - 38% of the parents reported attempting to get care for their child before Project K.I.N.D.
    - 96% of these parents reported inability to afford this care as the primary reason for their earlier failed attempts

POTENTIAL COST TO SOCIETY FOR NOT PROVIDING HEALTH INTERVENTION SERVICES

- Average estimated monetary cost for each acute care service provided was $350.00 (SD = $819.08), with a range of $33.00 to $6403.00

- 70% of the school nurses, 70% of the parents, and 38% of the health care providers reported that the child's acute health problem was moderately to highly interfering with the child's school functioning

Question 1

What are some potential consequences if the child's acute health problem had been left untreated?

Table 1

School Nurse and Provider Ratings of Consequences if Child Health Problem Left Untreated

If current child health problem was left untreated:	Nurse	Provider
Likely miss school for additional 1 to 3 days	65%	46%
Likely miss school for additional 4 to 5 days	45%	24%
Likely miss school for more than one week	40%	15%
Likely to be treated in ER	44%	42%
Likely to be hospitalized overnight	16%	18%
Likely to have lifetime productivity compromised	42%	38%

Note: Nurse N = 185-213
Provider N = 143-148

- *According to both school nurses and health care providers, if the child's health problem had been left untreated, the potential consequences to the child's school functioning, the child's overall health and lifetime productivity would be substantial*

Question 2

What are the relations between health care providers' estimates of the length of time the child had endured their health problem with other child health variables?

Table 2

Correlations between Provider Estimates of Length of Time Child Endured Health Problem with Other Child Health Variables

Provider estimates of length of time child endured health problem	r	N
1. Time provider spent with child	0.34**	198
2. Cost of health service provided	0.24**	197
3. Complexity of health service provided	0.45**	191
4. Interference with school	0.38**	115

**$p < 0.01$

- *As the amount of time without medical intervention increased, the amount of time the provider spent with the children, the cost of the health service, the complexity of the service, and the interference of the problem with school increased.*

PSYCHOLOGICAL PROFILE OF THE PARENT

Question 3

How adaptive are the beliefs parents have about their child's health?

- 34% of the parents of the referred children moderately to strongly agreed that their children's good health came from being lucky
- 86% of the parents agreed that they felt they could do many things to fight illness in their children
- 28% of the parents agreed that maintaining their children's health was a function of doing what others told them to do

- *The parents of this "working poor" sample perceive themselves as having control over their child's health, placing less emphasis on luck or on what others tell them to do*

Question 4

What are the relations between school nurse and parent ratings of parental health beliefs for their child?

Table 3
Correlations between School Nurse and Parent Ratings of Parental Health Beliefs for their Child

	1	2	3	4	5	6
1. Nurse--Parent feels child's health comes from being lucky/unlucky (LUCK)	1.00	-0.14*	0.44**	0.59**	-0.19*	0.35**
2. Nurse--Parent feels they have control over their child's health (CONTROL)	-0.14*	1.00	-0.26**	-0.042	0.13	-0.10
3. Nurse--Parent feels only health professionals have control over their child's health (OTHERS)	0.44**	-0.26**	1.00	0.32**	-0.15*	0.42**
4. Parent--LUCK	0.59**	-0.04	0.32**	1.00	-0.24**	0.42**
5. Parent--CONTROL	-0.19*	0.13	-0.15*	-0.24**	1.00	-0.19**
6. Parent--OTHERS	0.35**	-0.10	0.42**	0.42**	-0.19**	1.00

*$p < 0.05$; **$p < 0.01$; $N = 182$-213

- *School nurse perceptions of parental health beliefs for their child are consistent with parents' reported beliefs in terms of "Luck" and "Powerful Others," but not in terms of the "Control" parents feel they have over their child's health*

Question 5

Do school nurses' perceptions of parents' health beliefs for their child differ from parents' reported beliefs?

Table 4
ANOVA of School Nurse and Parent Ratings of Parental Health Beliefs for their Child

	M	F
Parent feels child's health comes from being lucky	Nurse: 2.6 Parent: 2.7	<1.0
Parent feels they have control over their child's health	Nurse: 4.0 Parent: 4.9	40.3**
Parent feels only health professionals have control over their child's health	Nurse: 2.8 Parent: 2.6	2.0

Note: $^{**}p < 0.001$; $N = 406\text{-}410$

- ***School nurses' judgments of the control "working poor" parents perceive with respect to their children's health is less than that of the parents' themselves, and may be susceptible to class stereotypes***

Question 6

What are the relations between parent health beliefs for their child and other child health variables?

Table 5
Correlations between Parent Health Beliefs for their Child and Other Child Health Variables

Parent--"Child's health comes from being lucky/unlucky"	r	N
1. Cost of health service provided	0.16*	192
2. Parent attempted to get care for child before Project K.I.N.D.	-0.25**	192
3. Mother occupational status	-0.21**	164
Parent--"Can do many things to fight illness in child"		
1. Cost of health service provided	-0.25**	193
Parent--"Only way to make child stay healthy is to do what others tell me to do"		
1. Cost of health service provided	0.19**	193
2. Mother occupational status	-0.17*	164
3. Percentage of adults in household	-0.17*	178

*$p < 0.05$; **$p < 0.01$

- *Adaptive parental beliefs about their child's health are related to demographic variables such as higher maternal occupational status and adult-to-child ratio in the household, lesser severity of child's acute health problem (as indicated by the cost of the health service), as well as previous attempts made by the parent to procure medical aid for their child.*

OVERALL CONCLUSIONS

- These results underscore the importance of early attention to acute childhood health problems
- Parents who are unable to provide medical care for their children's acute health care needs NEVERTHELESS:
    1) do notice that their children need health care and
    2) are active is trying to access health care for their children
- Medical professionals must be taught that to assume that most lower, middle class parents, often termed the "working poor", DESPITE their inability to easily access acute health care for their children, do try very hard to procure physical health care for their children.

- Too many children are falling through the cracks of our health care system; accurate assessment of the demographic and psychosocial characteristics of those children and their families AND use of these assessments to design prevention/intervention are among the first steps needed to improve our pediatric health care system